HEALTH FINANCE COMMISSION

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MEETING MINUTES[1]

Meeting Date:	**September 3, 2008**
Meeting Time:	**1:00 P.M.**
Meeting Place:	**State House, 200 W. Washington St., House Chamber**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**2**

Members Present: **Rep. Charlie Brown, Chairperson; Rep. Peggy Welch; Rep. John Day; Rep. Carolene Mays; Rep. Timothy Brown; Rep. Suzanne Crouch; Rep. Richard Dodge; Rep. David Frizzell; Rep. Don Lehe; Sen. Patricia Miller, Vice-Chairperson; Sen. Vaneta Becker; Sen. Connie Lawson; Sen. Vi Simpson.**

Members Absent: **Rep. Craig Fry; Rep. Phil Hoy; Rep. Scott Reske; Sen. Gary Dillon; Sen. Beverly Gard; Sen. Marvin Riegsecker; Sen. Ryan Mishler; Sen. Earline Rogers; Sen. Connie Sipes; Sen. Sue Errington.**

Chairperson Charlie Brown called the meeting to order at 1:15 PM and announced that due to the webcast, Commission members needed to use the microphones for questions or discussion.

SEA 493-2003 Update

Mitch Roob, Secretary, FSSA

Secretary Roob reviewed information displayed in his presentation regarding the implementation of SEA 493-2003. He reviewed each section of the bill that required action by

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.in.gov/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

FSSA and reported on the actions taken by the agency. (See Handout A.) The Secretary reported an increase in the number of individuals being served with Medicaid waiver services and a modest decrease in the number of individuals admitted to nursing facilities. With respect to Section 8 of the bill that requires the Office of Medicaid Policy and Planning to apply for federal approval to add 20,000 waiver slots, he reported that the agency had applied for the slots but had been denied. He added that Section 8 had expired, but that the Administration planned to apply for additional waiver slots when all the current slots have been filled. Secretary Roob reported that while SEA 493 was an influential piece of legislation with regard to refocusing the location of long-term care services from institutional settings to home and community-based settings, other legislation such as the quality assessment fee was beneficial to the transition process as well. He concluded by saying that to the best of his knowledge, FSSA had implemented all sections of SEA 493 even though some sections had expired.

There were Commission questions and discussion concerning the number of waiver slots available and filled, the number of individuals using self-directed care, and the $21 M Money Follows the Person federal grant.

In response to Commission questions regarding the need to reintroduce the content of the expired provisions of the bill, Secretary Roob commented that the expired sections could be implemented under existing administrative discretion. In response to a later question, he stated that it might be helpful to have statutory authority for the self-directed care option. Chairperson Brown asked if it was the will of the Commission to reauthorize those requirements contained in expired sections of SEA 493. Rep. Welch suggested that FSSA might have additional suggestions that could be of assistance to the agency in the implementation of the transition process.

Secretary Roob continued his presentation addressing proposed adjustments to nursing facility reimbursement intended to motivate the facilities to concentrate on high-needs patients and to discourage them from admitting lower-needs individuals who could be served in the community. He observed that the current reimbursement system provides incentives to the facilities to admit lower-needs patients in order to subsidize the costs of higher-need patients. He added that despite the large increase in net reimbursements to nursing facilities made possible by the quality assessment fee, quality of care as measured by the State Department of Health report cards had not improved. As a result, FSSA is looking at modifications to the quality assessment fee distribution and will be recommending a change in nursing facility reimbursement. The Secretary concluded by observing that not enough individuals are receiving in-home services; it will probably take a decade to achieve in-home care statistics comparable to the national average due to the lack of system capacity for in-home services. His plan is to shift some of the Medicaid dollars budgeted for nursing facilities to home and community-based services. He added that this information had been shared with the nursing home industry and that they had expressed some reservations with the timing but were generally supportive of the concept.

In response to a Commission question regarding potential cost savings, the Secretary commented that shifting the location of services provided to in-home settings should really be considered to be a zero-sum financial gain - it is budget neutral.

Commission questions and discussion followed with regard to measuring patient acuity, staffing turnover in nursing facilities, and transfers of patients from nursing facilities to in-home care.

<u>Vince McGowen, Hoosier Owners and Providers for the Elderly (HOPE)</u>

Mr. McGowen directed his comments to Secretary Roob's remarks regarding nursing facility reimbursement. He clarified that the proposals discussed with the Commission had been presented to the industry the day before. He agreed that conceptually there should be a shift in

reimbursement to discourage facilities from admitting lower-needs patients. He related difficulties associated with the certification process of converting an existing facility to an assisted-living waiver facility. Mr. McGowen stated that facilities try to comply with extensive regulations, compete for staff with other providers, and meet the daily needs of their patients. If they have a poor survey, they are penalized with civil fines, are denied the ability to train nurse aides, and are denied payment for new admissions until deficiencies are addressed. He commented that the facilities support diversions to in-home care and then are penalized for not meeting occupancy standards. Mr. McGowen added that the industry had expected nursing facility rate increases to be supplemented during the FY 2008-FY 2009 budget biennium with the Closure and Conversion Fund. He stated that even though costs grew at a slower pace than originally estimated and utilization declined, FSSA claims that the money in the Closure and Conversion Fund is now gone and no longer available. Mr. McGowen identified this as a serious problem for nursing facilities.

Commission questions and discussion followed with regard to Mr. McGowen's comments and the status of the Closure and Conversion Fund. Secretary Roob responded by saying that the industry had made some choices they now regret, and that they had received 80% of the quality assessment fee as required. He added that the Closure & Conversion Fund was an agreed-upon funding source and that it is now gone.

In the interest of the Commission's time, Chairperson Brown asked Mr. McGowen and Secretary Roob to submit their written positions on this issue to the Commission.

Steve Smith, Indiana Health Care Association (IHCA)

Mr. Smith commended the administration on the implementation of SEA 493. He stated that it was a huge change and was the right direction for the state. He also agreed with the Secretary that the ten-year estimate of time necessary to bring the state in line with national statistics on the provision of in-home care was a realistic plan. Mr. Smith stated that capacity building is a function of rates; if the rate structure is appropriate, the capacity will be developed. He added that nursing facilities are the only service reimbursed by Medicaid based on cost - not daily rates. He commented that rates should be fixed by high, medium, and low acuity classifications with the rates for in-home services potentially overlapping the institutional range of rates. Mr. Smith discussed the problem of high staff turnover and suggested that providers should be given a daily rate; the providers could use it for staff wages and benefits to address retention issues. This suggestion would provide flexibility for the providers.

Commission questions followed with regard to how corporations not based in this state would use money reimbursed on other than a cost basis. Mr. Smith responded that nursing facilities spend a lot of money on staff training; it is to their advantage to retain their trained staff. He then suggested that the rates could be indexed to wage rates.

Trauma Centers

Chairperson Brown announced that the lack of an available trauma care provider is an ongoing issue for Northwest Indiana that needs to be addressed, although the subject of trauma center availability was not a required topic for the Commission.

Tim Kennedy, Indiana Hospital Association

Mr. Kennedy stated that there are currently seven certified trauma centers in Indiana; three are Level 1 centers, four are Level 2 centers. Another facility is working on the Level 2 certification process.

H. Scott Bierke, MD, FACS, Trauma Surgeon, Clarion Hospital, Indianapolis

Dr. Bierke, representing a Level 1 trauma center, testified that Level 1 centers are staffed in-house, 24 hours a day, 7 days a week. Trauma centers decrease death and disabilities by targeting the treatment of serious injuries within one hour of occurrence. (See Handout B.) He discussed the staffing, level of coverage, and the specialists necessary for a Level 1 trauma center designation. Dr. Bierke explained that patient care is not different between the designated levels of trauma care but that Level 1 centers also serve as a resource for education, training, and research. Trauma centers require a real institutional commitment along with a large financial outlay. Trauma centers take all patients regardless of their ability to pay.

Jayne Mitton, Executive Director, Surgical & Trauma Services, Memorial Hospital, South Bend

Ms. Mitton, representing a Level 2 trauma center, testified that Level 2 centers do not have an affiliation with a university and don't provide education. She stated that providers must respond within 15 minutes and there must be medical and administrative directors for trauma services. Ms. Mitton added that it took Memorial Hospital six years of work to develop all of the required services. She discussed staffing needs and services that must be available for the trauma center. Certified facilities provide a lot of training, and the facility undergoes periodic recertification. She discussed patient volumes and unreimbursed patient care costs of approximately $8 M annually. (See Handout C.) In response to a Commission question, Ms. Mitton explained that patients come from the geographic region of the hospital and that hospitals in the surrounding region do not contribute to the cost of the trauma services.

Cary Hanni, MD, Medical Director of Trauma, Deaconess Hospital, Evansville

Dr. Hanni, representing a Level 3 trauma center that is certified in Indiana and Illinois and serving patients from three states, stated that the trauma center is staffed by private physicians only - there are no residents. These physicians also provide advanced trauma life support training in the region. He stated that seriously injured people are expensive to care for and that the hospital had lost $8 M providing trauma care. Dr. Hanni testified that the Deaconess trauma center is also certified by the American College of Surgeons (ACS), which had reviewed the Illinois trauma system. Illinois has the oldest trauma system in the country. The ACS found that most of the problems in the Illinois system related to a lack of funding. Dr. Hanni thanked the members of the legislature for the work done so far and asked them to consider the funding issue revealed in Illinois as the system is developed in Indiana.

In response to Commission questions, Dr. Hanni clarified that circumstances dictate whether a patient would be transported directly to a trauma center or stabilized at a local hospital before transfer to the trauma center. He also explained that the emergency department is a part of the trauma center and that minor injuries would not be seen by the trauma center.

Lewis Jacobson, MD, Trauma Surgeon, IU/Wishard Memorial Hospital, Indianapolis

Dr. Jacobson, representing a Level 1 trauma center, testified that Wishard was the first ACS-certified facility in Indiana. He described the hospital governance and ownership. Wishard was first certified in 1992 and has had five subsequent ACS verification visits, which are required every three years. Wishard also operates one of the oldest ambulance services in the country. Dr. Jacobson stated that with 105,000 emergency department patient visits. the Wishard emergency department is the busiest in the state. He explained that there are various levels of activation for the trauma team. One situation may require a team of 15 -20 professionals; others a different response level. He also explained that patients must meet certain clinical criteria for trauma team activations. Examples of injuries would include shock, blunt force injuries, penetrating injuries, burns, and others. Dr. Jacobson stated that Wishard operates the

only burn center in the state. He discussed the volume of patients seen by the trauma center and the sources of payment. He also explained that Wishard is a patient resource for the IU School of Medicine. (See Handout D.)

In response to Commission questions regarding how each patient's level of care is determined, Dr. Jacobson explained that the availability of specialists is a basic requirement for trauma center designation. He also defined the term "golden hour," which indicates that the majority of trauma patients need to be seen in the first hour after injury to improve their chances for survival or limiting disability. The trauma system is designed so that all the required specialists for a patient with multiple injuries are immediately available. He added that if a hospital is not a trauma center, specialists may or may not be immediately available. They may be on call. He explained that once the golden hour is exceeded, the patient's chances for survival go down.

In response to Commission questions regarding how patients get to a trauma center, Rep. Tim Brown, MD, who is an emergency department physician, explained that the goal of a community hospital emergency department is to stabilize the patient before transfer to a trauma center. There were additional questions about the EMS transportation system in relation to the trauma centers.

Debbie Poole, Executive Director of Trauma, St. Mary's Medical Center, Evansville

Ms. Poole testified that of 46,000 annual emergency department patients, 22% were trauma cases. (See Handout E.) She added that 21% of the trauma injuries were related in some manner to abuse of drugs and alcohol. She explained the tiered level of trauma response by defined clinical criteria. Ms. Poole explained that hospitals pay activation fees to providers, which is quite expensive. She discussed the fact that federal law requires that the trauma center have notification of a trauma patient's imminent arrival in order to bill for the provider's activation fees. If a patient arrives at the trauma center without notification from an EMS transport or a transferring hospital, the center cannot bill for the response fees.

Commission questions followed with regard to the specific federal citation, the percentage of patients that arrive by ambulance, and the percentage of charges not reimbursed due to the lack of notification.

Mary Aaland, MD, Trauma Medical Director, Parkview Hospital, Fort Wayne

Dr. Aaland, representing a Level 2 trauma center, testified that trauma is the number one cause of death for young people. She discussed what clinical criteria constitute a trauma case. She explained that the majority of injured patients do not require a full trauma response - only 10-15% of the cases require a full response. She noted that prior to 2000, the only trauma center in the state was in Indianapolis. Dr. Aaland commented that trauma care has to be considered as a public service. She noted that certain regions of the state have regional trauma coverage while others do not and that the cost of providing this coverage is significant. She recognized that Northwest Indiana and Gary in particular has a real problem with regard to trauma access. Dr. Aaland stated that Indiana needs to be organized in order to get patients to the most appropriate facility as fast as possible and to provide better service coverage statewide. (See Handouts F.)

Claude Watts, Retired CEO, Methodist Hospital, Gary

Mr. Watts noted that Northwest Indiana has no designated Level 1 or Level 2 trauma center. For years, this corner of the state has relied on trauma centers located in Illinois. However, for trauma patients, time is a commodity; immediate intervention saves lives and reduces disabilities. He stated that Northwest Indiana has several major transportation arteries that

cross the area; serious motor vehicle accidents resulting in major blunt force injuries are common. Additionally, this is an urban area and many penetrating injuries, gunshot wounds, and stabbing victims are seen in the emergency department. He added that 10% of Methodist Hospital's emergency patients have to be transferred - and that is the percentage from Methodist only. There are eight other hospitals in Northwestern Indiana. Mr. Watts testified that a Level I or Level 2 trauma center is needed in Northwest Indiana, but funding assistance will be required to support the high cost of trauma care.

Commission discussion and questions followed with regard to the level of local commitment to supporting this need, the cost of recruiting for specialists, and the role of Medicaid disproportionate hospital share payments to trauma care. In response to an observation that Methodist Hospital is not a certified trauma center but acts like one, Mr. Watts commented that Methodist could not meet the certification requirements due to the lack of certain key specialists. Commission discussion followed with regard to the expense of recruiting specialists in the Chicago market. Mr. Watts stated that the closest trauma center had closed in July 2008, leaving two Level 1 centers in the Chicago area available for the transfer of patients if they will accept them.

Mr. Watts testified that Maryland has a coordinated trauma system funded by a fee attached to vehicle registrations.

Patrick Bankston, PhD, Assistant Dean and Director, Professor of Anatomy and Pathology, IU School of Medicine - Northwest

Dean Bankston submitted his testimony in writing. (See Handout G.)

Michael McGee, MD, Director of Emergency Services, Methodist Hospital, Gary

Dr. McGee testified that Methodist Hospital pays doctors to provide on-call service. The need to provide on-call pay for trauma and emergency coverage is an issue that is affecting hospitals all over the country. There is a need for funding for this service. Dr. McGee stated that the recent closure of a trauma center in Illinois affected all Northwest Indiana hospitals. He discussed the geographic location of Gary with respect to the transportation network and the resulting motor vehicle accidents. He also commented on the high number of penetrating traumas experienced in the urban environment of the city. Dr. McGee discussed the data presented in Handout H. He also stated that in addition to treatment of penetrating trauma, the community is also exploring obtaining prevention funding available for strategic intervention. He described the process of attempting to transfer a trauma patient to an Illinois trauma center. He explained that the Chicago trauma centers may not accept patients from Indiana for various reasons. Dr. McGee stated that Methodist Hospital needs help to upgrade their emergency department to the level of trauma care. He added that a Level 2 trauma designation should be an intermediate step with the goal being to establish a Level 1 center. Dr. McGee commented that Porter Memorial Hospital has expressed some interest in seeking a trauma designation but that Valparaiso may not be an ideal location to serve all of Northwest Indiana. He described some local efforts to provide for funding, including the establishment of a trauma foundation and looking for available grants. Dr. McGee stated that at some point Gary will have a trauma center - it is going to happen.

Commission discussion followed with regard to the need for federal financial support for this issue.

Kwana Shaw

Ms. Shaw related her experience as a trauma patient and noted that had a pediatric surgeon

been available, her son might also have survived.

Chairperson Brown announced that due to time constraints, the FSSA eligibility modernization issue would be heard at another meeting of the Commission. He then called for remaining testimony on the SEA 493 implementation.

John Cardwell, Director, Generations Project

Mr. Cardwell stated that from a consumer point of view, only some progress had been made on the implementation of SEA 493. He commented that there are still requirements not being performed and that the state should be able to fully develop in-home services in line with the national average within five years, not a decade. He added that he would support renewing sections of SEA 493 that have expired. Mr. Cardwell stated that a waiver regulation implemented this summer limits the number of hours of service to clients. This effectively limits the opportunity for clients to use services and ultimately determines if the in-home care will work for the client. Mr. Cardwell explained that the intake system needs to offer people in-home service before they enter institutional care. This mainly happens in the hospital. He stated that other states have state employees based in hospitals in order to limit inappropriate placements in nursing facilities.

Mr. Cardwell described a survey process his organization had undertaken. (See Handout I.) They ask people what their problems were in accessing services. He said a recurring theme was that the FSSA modernization process is having a negative impact on the ability of clients to access in-home services and that clients need caseworkers in the county offices.

Commission discussion followed with regard to the eligibility modernization pilot projects. In response to a request from Chairperson Brown, Mr. Cardwell gave a brief explanation of self-directed care. Mr. Cardwell commented that this option is underutilized in Indiana in comparison to other states. He added that the Arizona-based fiscal intermediary is slow in responding to clients inquiries.

Ann Alley, Director of Primary Care, Indiana State Department of Health

Ms. Alley explained that the trauma system development activities of the State Department of Health are authorized by P.L. 155-2006. The trauma system development effort is housed within the Primary Care Division and is funded with $367,000 in federal dollars. The Department and the 50-member Advisory Task Force for Trauma System and Emergency Preparedness has worked together to develop the necessary components of the trauma system. Ms. Alley discussed the activities of the Advisory Task Force and the development of the Trauma Registry pilot project. She stated that the Department and the seven certified trauma centers in the state will be funding a comprehensive assessment of Indiana's trauma system by the American College of Surgeons. The review is scheduled to begin in January 2009. (See Handout J for written testimony.)

Chairperson Brown announced the topics to be discussed at the next meeting.

The meeting was adjourned at 4:15 PM.